

Health and Recovery Services Administration
ADHD CONSULTATION
PLEASE RETURN THIS FAX TO: (360) 725-2122

Date: _____

Internal Use Only

Reference #:

PIC:

MAS:

Thank you for reviewing the clinical documentation for:

Client Name _____ **date of birth:** _____ with the diagnosis of

Medical Condition _____ being treated with

Medication/dose/frequency _____.

The current medication regimen will be continued until the department reviews your recommendations. New starts for the age of 5 and over will only be allowed at the dosage recommendations of the Mental Health Stakeholder Work Group.

Record Review Section:

After reviewing the clinical records, diagnosis, attachments, and treatment request, I am:

☐ Recommending no changes to the drug therapy. There is a clear clinical history, supporting research, and appropriate diagnosis in which the benefits outweigh the harm at the above dosage, frequency and combination requested.

OR

☐ Recommending a change to the drug therapy because the above request is not supported by the diagnosis, clinical notes, research and/or other documentation due to (check one or more below):

AND/OR

☐ Recommending a change in drug therapy for **other** than ADHD drugs because (check one or more below):

☐ The diagnosis is not supported by the clinical notes.

☐ There is insufficient documentation of symptoms and clinical rationale.

☐ There is insufficient clinical literature to support the treatment and the harm may be greater than benefit.

☐ My objective findings are (if other than the above):

(Please complete "Recommendation" section below, too)

OR

☐ Recommending a clinical consultation and referral to my office for further evaluation before any conclusions can be made. The client is scheduled for an appointment on:

(Month) _____ (Day) _____ (Time) ____:____ (Please fax form to HRSA as FYI)

Reminder: Please complete the "recommendations" section at time of consultation and fax to HRSA

My treatment recommendation(s), based on my record review and/or office visit, are (list diagnosis, drug, dose, frequency and/or other below): _____

Name (print): _____

Signature: _____ Date: _____

Billing Information

Psychiatric evaluation of records: ***Use billing code-*** 90885

Preparation of report: ***Use billing code-*** 90889

Office Consultation: ***Use a billing code between:*** 99241 – 99245

Telemedicine Consultation: ***Use billing codes-*** Facility Fee @ Client site - Q3014

Facility Fee @ Consultation site - 99241-99245 with Modifier GT